TITLE 9. HEALTH SERVICES

CHAPTER 7. DEPARTMENT OF HEALTH SERVICES CHILDREN'S REHABILITATIVE SERVICES

Editor's Note: New 9 A.A.C. 7 made by final rulemaking at 10 A.A.R. 691, effective April 3, 2004. The rescinded 9 A.A.C. 7 is on file in the Office of the Secretary of State (Supp. 04-1).

Editor's Note: 9 A.A.C. 7 expired under A.R.S. § 41-1056(E) at 8 A.A.R. 4591, effective August 31, 2002. The Office of the Secretary of State publishes all Code Chapters on white paper (Supp. 02-4).

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ARTICLE 1. DEFINITIONS

Article 1, consisting of Section R9-7-101, made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

R9-7-101. Definitions

In this Chapter, unless otherwise specified:

1. "Activity of daily living" means ambulating, dressing, bathing, showering, grooming, preparing food, toileting, eating, drinking, communicating, or moving into or out of a bed or chair.
2. "Acute" means requiring immediate medical treatment.
3. "Adult" means an individual 21 years of age or older.
4. "AHCCCS" means the Arizona Health Care Cost Containment System.
5. "Ambulation assistive device" means a walker, cane, or crutch.
6. "Applicant" means an individual requesting enrollment who is:
   a. A child, or
   b. An adult with cystic fibrosis or sickle cell anemia.
7. "Application packet" means an application form containing the information in R9-7-304(1) and additional documentation required by the Department to determine:
   a. Whether an individual is eligible for CRS; and
   b. If the individual is eligible for CRS, the payment responsibility of the individual or, if the individual is a minor, the individual's parent.
8. "Behavioral health service" has the same meaning as in A.A.C. R9-20-101.
9. "Biologicals" means medicinal compounds prepared from living organisms and the product of living organisms such as serums, vaccines, antigens, and antitoxins.

10. "Business day" means Monday, Tuesday, Wednesday, Thursday, or Friday excluding state and federal holidays.
11. "Child" means an individual less than 21 years old.
12. "Chronic" means expected to persist over an extended period of time.
13. "Communication disorder" means an abnormality of functioning related to the ability to express or receive ideas.
14. "Co-payment" means the amount the Department requires a member to pay to a CRS provider for a medical service.
15. "Covered" means authorized and provided by or through the Department.
16. "Crisis intervention service "means a behavioral health service provided for a limited period of time to a member who is a danger to others as defined in A.A.C. R9-20-101 or a danger to self as defined in A.A.C. R9-20-101.
17. "CRS" means Children's Rehabilitative Services, a program administered by the Department to provide covered medical services and covered support services.
18. "CRS clinic" means outpatient evaluation and treatment provided by more than one specialist at a specific location for a scheduled period of time.
19. "CRS condition" means any of the medical conditions in Article 2 of this Chapter that make an individual medically eligible for CRS.
20. "CRS provider" means a person who is authorized by employment or written agreement with the Department or a regional contractor to provide covered medical services to a member or covered support services to a member or a member's family.
21. "Dental services" means treatment provided by a dentist or a dental hygienist.
22. "Dental hygienist" means an individual licensed under A.R.S. Title 32, Chapter 11, Article 4.
23. "Dentist" means an individual licensed under A.R.S. Title 32, Chapter 11, Article 2.
24. "Department" means the Arizona Department of Health Services.
25. "Dependent care" means supervision and guidance provided to an individual by a person other than the individual's parent.
26. "DES" means the Arizona Department of Economic Security.
27. "Diagnosis" means a determination or identification of a CRS condition made by a physician.
28. "Earned income" means monies or other compensation received as wages, tips, salary, or commissions by an individual or profit from activities in which a self-employed individual is engaged.
29. "Eligibility interview" means an interaction between a Department representative and an applicant or member or, if the applicant or member is a minor, the applicant's or member's parent to review the documentation in R9-7-304(2) through (11).
30. "Eligible" means:
    a. Meeting the medical and non-medical eligibility requirements in A.R.S. Title 36, Chapter 2, Article 3 and this Chapter; or
    b. Meeting the requirements for obtaining Title XIX or Title XXI health care insurance.
31. "Emergency" means an immediate threat to the health or life of a member.
32. "Emergency services" has the same meaning as in A.A.C. R9-10-201.
33. "Enrollment" means the Department's approval for an eligible individual to be a member.
34. "Evaluation" means an analysis of an individual's emotional, mental, physical, psychological, or social condition to make a diagnosis or to determine the individual's need for medical services or social services.
35. "Expiration date" means:
    a. The date on which a member's enrollment ends, or
    b. The date on which an individual's Title XIX or Title XXI health care insurance ends.
36. "Facility" means a building or portion of a building.
37. "Family" means a member's parent and each individual included in the member's household income group.
38. "Federal Poverty Level" means the current level of income set by the United States government, based on family size, that is used to determine whether an individual may receive low income federal assistance.
39. "Fee-for-service" means reimbursement for a medical service at an established rate.
40. "Functional improvement" means an increase in an individual's ability to perform an activity of daily living.
41. "Functionally limiting" means a restriction having a significant effect on an individual's ability to perform an activity of daily living as determined by a specialist.
42. "Gross income" means the total of earned income and unearned income.
43. "Health care insurance" means a contractual arrangement for a person to provide, directly or indirectly, all or a portion of the medical, dental, or behavioral health care needs of an individual.
44. "Health care insurance premium" means compensation or monies paid by an individual to a person for the individual's health care insurance.
45. "Hearing aid" means a small, electronic device that amplifies sound.
46. "Hearing evaluation" means testing of an individual's hearing and an analysis of the testing to determine the type and degree of an individual's hearing loss.
47. "Hearing impairment" means any type or degree of hearing loss that interferes with an individual's development or adversely affects an individual's ability to perform activities of daily living.
48. "Hearing screening" means testing to determine whether an individual has a hearing loss.
49. "Home health services" has the same meaning as in A.R.S. § 36-151.
50. "Hospital" has the same meaning as in A.R.S. § 36-2351.
51. "Household income group" means all of the individuals whose income the Department includes when calculating payment responsibility for covered services.
52. "Initial evaluation" means an examination of an applicant by a CRS provider to determine whether the applicant meets the medical eligibility requirement for enrollment.
53. "Inpatient services" means "hospital services" as defined in A.A.C. R9-10-201 that are provided to an individual who is anticipated to receive hospital services for 24 consecutive hours or more.
54. "Medical expenses" means charges incurred by an individual for medical equipment, medication or biologicals prescribed by a physician or specialist, dental services, treatment by a physician or specialist, inpatient services, outpatient services, or health care insurance premiums for the individual.
55. "Medically eligible" means meeting the medical eligibility requirements of A.R.S. Title 36, Chapter 2, Article 3 and this Chapter.

56. "Medically necessary" means essential for ameliorating or preventing the development or progression of a medical condition.
57. "Medical service" means evaluation or treatment of a member by a physician or specialist who is a CRS provider.
58. "Medication" has the same meaning as "drug" in A.R.S. § 32-1901.
59. "Member" means an individual who receives covered medical services and covered support services from the Department through CRS.
60. "Minor" means an individual who is:
    a. Under the age of 18 years,
    b. Incompetent as determined by a court of competent jurisdiction, or
    c. Incapable of giving consent for medical services due to a limitation in the individual's cognitive function as determined by a physician.
61. "Nursing services" has the same meaning as in A.R.S. § 36-401.
62. "Nutrition" means food and liquid required for a human body's maintenance and growth.
63. "Occupational therapy" has the same meaning as in A.R.S. § 32-2001.
64. "Orthotic device" means equipment used by an individual to preserve, restore, or develop the individual's musculoskeletal system including the individual's extremities or spine.
65. "Outpatient services" means evaluating, monitoring, or treating an individual at a facility, physician's office, regional clinic, or outreach clinic for less than 24 hours.
66. "Outreach clinic" means a facility or a specific location in a facility designated by a regional contractor to provide covered medical services or covered support services in a setting other than a regional clinic.
67. "Parent" means a biological or adoptive mother or father of a child, or an individual who is a court-appointed legal guardian or custodian of an individual.
68. "Payment agreement" means a form containing a member's signed, written promise to pay for covered medical services according to the terms on the form.
69. "Payment responsibility" means that portion of the cost for medical services that a member is required to pay and has agreed to pay according to a signed written agreement.
70. "Person" has the same meaning as in A.R.S. § 1-215 and includes a governmental agency.
71. "Pharmaceutical services" means medications and biologicals ordered by a physician, dentist, physician's assistant, or nurse practitioner.
72. "Physical therapy" has the same meaning as in A.R.S. § 32-3401.
73. "Physician" means an individual licensed under A.R.S Title 32, Chapter 13 or Chapter 17.
74. "Physician services" has the same meaning as "practice of medicine" in:
    a. A.R.S. § 32-1401, for a physician licensed under A.R.S. Title 32, Chapter 13;
    b. A.R.S. § 32-1800, for a physician licensed under A.R.S. Title 32, Chapter 17.
75. "Prior authorization" means a written approval signed by a regional contractor or the regional contractor's designee before a covered service is provided to a member.
76. "Prosthetic device" means equipment used as a substitute for a diseased or missing part of the human body.
77. "Provide" means to directly or indirectly under the terms of a contract make available or furnish medication, medical equipment, or services in this Chapter to an applicant or a member.
78. "Psychiatrist" has the same meaning as in A.R.S. § 36-501.
79. "Psychiatric services" means physician services provided by a psychiatrist.
80. "Psychologist" means an individual licensed under A.R.S. Title 32, Chapter 19.1.
81. "Psychological services" has the same meaning as in A.R.S. § 32-2061.
82. "Psychosocial evaluation" means an analysis of an individual's mental and social conditions to determine the individual's need for social services.
83. "Qualified alien" has the same meaning as in A.R.S. § 36-2903.03(G).
84. "Refer" means to inform CRS in writing of an individual who may be eligible for CRS.
85. "Referral source" means a person who refers an individual.
86. "Redetermination" means a decision made by the Department regarding whether a:
    a. Member continues to be eligible for CRS, or
    b. Member's payment responsibility is changed.
87. "Regional clinic" means a facility or specific location in a facility designated by a regional contractor:
    a. To provide covered medical services and covered support services, and
    b. As the location for the regional contractor's administrative office.
88. "Regional contractor" means a person who has a written agreement with the Department to provide covered medical services and covered support services.
89. "Regional medical director" means a physician employed by a regional contractor to make:
    a. Medical determinations about members, and
    b. Prior authorizations for medical services provided to members.
90. "School" means a:
    a. Charter school as defined in A.R.S. § 15-101,
    b. Private school as defined in A.R.S. § 15-101,
    c. School as defined in A.R.S. § 15-101, or
    d. Child care facility as defined in A.R.S. § 36-881.
91. "Session" means a period of time during which a member continuously receives a specific treatment from a CRS provider.
92. "Social worker" means an individual certified under A.R.S. Chapter 33, Article 5.
93. "Social work services" has the same meaning as "practice of social work" in A.R.S. § 32-3251.
94. "Specialist" means:
    a. A physician who is a CRS provider with professional education, knowledge, and skills related to a specific service or procedure, age category of patients, body system, or type of disease; or
    b. A CRS provider, other than a physician, who requires specific professional education, knowledge, and skills to deliver a medical service or support service.
95. "Supervision and guidance" means assistance provided to an individual to safeguard the individual's health and safety or to perform an activity of daily living.
96. "Support service" means non-medical assistance provided by a CRS provider to a member or a member's

family without charge to the member or the member's family.

97. "Title XIX" means the Federal Medicaid Program, a health care insurance program through which eligible individuals receive health care, that is administered jointly by the U.S. Department of Health and Human Services and, in Arizona, by AHCCCS.
98. "Title XXI" means the State Children's Health Insurance Program, through which eligible children receive health care insurance that is administered by AHCCCS.
99. "Total parenteral nutrition" means the intravenous infusion of nutrients required by an individual into the individual through a catheter.
100. "Treatment" means a procedure or method used to cure, improve, or palliate an injury, an illness, or a disease.
101. "Unearned income" means monies received by an individual for which the individual did not perform labor.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

ARTICLE 2. ELIGIBILITY

Article 2, consisting of Sections R9-7-201 through R9-7-203, made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

R9-7-201. Eligibility Requirements

A. An individual is eligible to enroll for CRS if the individual:
1. Has one of the medical conditions in R9-7-202;
2. Except as provided in subsection (B), is a child;
3. Is one of the following:
   a. A U.S. citizen, or
   b. A qualified alien who meets the requirements of A.R.S. § 36-2903.03(B), and
4. Is living in Arizona and intends to continue living in Arizona.

B. The Department may enroll an adult, who is not eligible for Title XIX health care insurance, in CRS if:
1. The adult has cystic fibrosis and monies are appropriated to the Department under A.R.S. § 36-143, or
2. The adult has sickle cell anemia and monies are appropriated to the Department under A.R.S. § 36-797.44.

C. The Department shall continue a member's enrollment in CRS if the member:
1. And, if the member is a minor, the member's parent comply with the requirements in this Chapter;
2. Meets the requirements in subsections (A)(1), (A)(2), and (A)(4); and
3. Meets the requirements in subsection (A)(3) or has continuously been a member since August 5, 1999.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

R9-7-202. Medical Conditions

An individual is medically eligible for CRS, only if the individual has:

1. One or more of the following cardiovascular system medical conditions:
   a. Congenital heart defect,
   b. Cardiomyopathy,
   c. Valvular disorder,
   d. Arrhythmia,
   e. Conduction defect,
   f. Rheumatic heart disease that is not in the acute phase,
   g. Renal vascular hypertension,
   h. Arteriovenous fistula, and
   i. Kawasaki disease with coronary artery aneurysm;
2. One or more of the following endocrine system medical conditions:
   a. Hypothyroidism;
   b. Hyperthyroidism;
   c. Adrenogenital syndrome;
   d. Addison's disease;
   e. Hypoparathyroidism;
   f. Hyperparathyroidism;
   g. Diabetes insipidus;
   h. Cystic fibrosis;
   i. For an individual who was a member before November 1, 1995, panhypopituitarism with a deficiency of growth hormone; and
   j. For an individual who became a member or applies for enrollment after November 1, 1995, panhypopituitarism with a deficiency of growth hormone and two other pituitary hormones;
3. One or more of the following genitourinary system medical conditions:
   a. Vesicoureteral reflux, with at least mild or moderate dilatation and tortuosity of the ureter and mild or moderate dilatation of renal pelvis;
   b. Ectopic ureter;
   c. Ambiguous genitalia;
   d. Ureteral stricture;
   e. Complex hypospadias;
   f. Hydronephrosis;
   g. Deformity and dysfunction of the genitourinary system secondary to trauma after the acute phase of the trauma has passed;
   h. Pyelonephritis when treatment with drugs or biologicals has failed to cure or ameliorate and surgical intervention is required;
   i. Multicystic dysplastic kidneys;
   j. Nephritis associated with lupus erythematosis; and
   k. Hydrocele associated with a ventriculo-peritoneal shunt;
4. One or more of the following ear, nose, or throat medical conditions:
   a. Cholesteatoma;
   b. Chronic mastoiditis;
   c. Deformity and dysfunction of the ear, nose, or throat secondary to trauma, after the acute phase of the trauma has passed;
   d. Neurosensory hearing loss;
   e. Congenital malformation;
   f. Significant conductive hearing loss due to an anomaly in one ear or both ears equal to or greater than a pure tone average of 30 decibels, that despite medical treatment, requires a hearing aid;
   g. Craniofacial anomaly that requires treatment by more than one specialist; and
   h. Microtia that requires multiple surgical interventions;
5. One or more of the following musculoskeletal system medical conditions:
   a. Achondroplasia;
   b. Hypochondroplasia;
   c. Diastrophic dysplasia;
   d. Chondrodysplasia;
   e. Chondroectodermal dysplasia;
   f. Spondyloepiphyseal dysplasia;
   g. Metaphyseal and epiphyseal dysplasia;

h. Larsen syndrome;
i. Fibrous dysplasia;
j. Osteogenesis imperfecta;
k. Rickets;
l. Enchondromatosis;
m. Juvenile rheumatoid arthritis;
n. Seronegative spondyloarthropathy;
o. Orthopedic complications of hemophilia;
p. Myopathy;
q. Muscular dystrophy;
r. Myoneural disorder;
s. Arthrogryposis;
t. Spinal muscle atrophy;
u. Polyneuropathy;
v. Chronic stage bone infection;
w. Chronic stage joint infection;
x. Upper limb amputation;
y. Syndactyly;
z. Kyphosis;
aa. Scoliosis;
bb. Congenital spinal deformity;
cc. Congenital cervical spine abnormality;
dd. Developmental cervical spine abnormality;
ee. Hip dysplasia;
ff. Slipped capital femoral epiphysis;
gg. Femoral anteversion and tibial torsion that is:
  i. For an individual less than eight years of age, associated with a neuromuscular disorder that is a CRS condition; or
  ii. For an individual eight years of age or older, causing significant functional impairment, as determined by a CRS provider;
hh. Legg-Calve-Perthes disease;
ii. Lower limb amputation, including prosthetic sequelae of cancer;
jj. Metatarsus adductus;
kk. Leg length discrepancy of five centimeters or more;
ll. Metatarsus primus varus;
mm. Dorsal bunions;
nn. Collagen vascular disease;
oo. Benign bone tumor;
pp. Deformity and dysfunction secondary to musculoskeletal trauma if:
  i. The patient was 15 years of age or younger at the time of initial injury, and
  ii. The deformity and dysfunction is not in the acute phase;
qq. Osgood Schlatter's disease that requires surgical intervention; and
rr. Complicated flat foot, such as rigid foot, unstable subtalar joint, or significant calcaneus deformity;

6. One or more of the following gastrointestinal system medical conditions:
   a. Tracheoesophageal fistula;
   b. Anorectal atresia;
   c. Hirschsprung's disease;
   d. Diaphragmatic hernia;
   e. Gastroesophageal reflux that has failed treatment with drugs or biologicals and requires surgery;
   f. Deformity and dysfunction of the gastrointestinal system secondary to trauma, after the acute phase of the trauma has passed;
   g. Biliary atresia;
   h. Congenital atresia, stenosis, fistula, or rotational abnormalities of the gastrointestinal tract;
   i. Cleft lip;
   j. Cleft palate;
   k. Omphalocele; and
   l. Gastroschisis;
7. One or more of the following nervous system medical conditions:
   a. Uncontrolled seizure disorder, in which there have been more than two seizures with documented adequate blood levels of one or more medications;
   b. If the individual is not eligible for Title XIX or Title XXI health care insurance and does not have other health care insurance, simple or controlled seizure disorders;
   c. Cerebral palsy;
   d. Muscular dystrophy or other myopathy;
   e. Myoneural disorder;
   f. Neuropathy, hereditary or idiopathic;
   g. Central nervous system degenerative disease;
   h. Central nervous system malformation or structural abnormality;
   i. Hydrocephalus;
   j. Craniosynostosis of a sagittal suture, a unilateral coronal suture, or multiple sutures in a child less than 18 months of age;
   k. Myasthenia gravis, congenital or acquired;
   l. Benign intracranial tumor;
   m. Benign intraspinal tumor;
   n. Tourette's syndrome;
   o. Residual dysfunction after resolution of an acute phase of vascular accident, inflammatory condition, or infection of the central nervous system;
   p. Myelomeningocele, also known as spina bifida;
   q. Neurofibromatosis;
   r. Deformity and dysfunction secondary to trauma in an individual 15 years of age or less at the time of the initial injury;
   s. Sequelae of near drowning, after the acute phase; and
   t. Sequelae of spinal cord injury, after the acute phase;
8. One or more of the following ophthalmological medical conditions:
   a. Cataracts;
   b. Glaucoma;
   c. Disorder of the optic nerve;
   d. Non-malignant enucleation and post-enucleation reconstruction;
   e. Retinopathy of prematurity; and
   f. Disorder of the iris, ciliary bodies, retina, lens, or cornea;
9. One or more of the following respiratory system medical conditions:
   a. Anomaly of the larynx, trachea, or bronchi that requires surgery; and
   b. Nonmalignant obstructive lesion of the larynx, trachea, or bronchi;
10. One or more of the following integumentary system medical conditions:
   a. A craniofacial anomaly that is functionally limiting,
   b. A burn scar that is functionally limiting,
   c. A hemangioma that is functionally limiting,
   d. Cystic hygroma, and
   e. Complicated nevi requiring multiple procedures;
11. One or more of the following genetic and metabolic medical conditions:
   a. Amino acid or organic acidopathy,
   b. Inborn error of metabolism,
   c. Storage disease,

d. Phenylketonuria,
e. Homocystinuria,
f. Hypothyroidism,
g. Maple syrup urine disease, and
h. Biotinidase deficiency;
12. Sickle cell anemia or other hemoglobinopathy; or
13. A medical condition, other than one of the conditions in R9-7-203, that, as determined by a regional medical director:
a. Requires specialized treatment similar to the type and quantity of treatment a medical condition in subsections (1) through (12) requires,
b. Is as likely to result in functional improvement with treatment as a medical condition listed in subsections (1) through (12), and
c. Requires long-term follow-up of the type and quantity required for a medical condition listed in subsections (1) through (12).

Historical Note

New Section made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

R9-7-203. Medical Ineligibility

An individual who has one or more of the following medical conditions, but does not have one or more of the medical conditions in R9-7-202, is not medically eligible for CRS:

1. The following cardiovascular system medical conditions:
a. Essential hypertension;
b. Premature atrial, nodal or ventricular contractions that are of no hemodynamic significance;
c. Arteriovenous fistula that is not expected to cause cardiac failure or threaten loss of function; and
d. Benign heart murmur;
2. The following endocrine system medical conditions:
a. Diabetes mellitus,
b. Isolated growth hormone deficiency,
c. Hypopituitarism encountered in the acute treatment of a malignancy, and
d. Precocious puberty;
3. The following genitourinary system medical conditions:
a. Nephritis, infectious or noninfectious;
b. Nephrosis;
c. Undescended testicle;
d. Phimosis;
e. Hydrocele not associated with a ventriculo-peritoneal shunt;
f. Enuresis;
g. Meatal stenosis; and
h. Hypospadias involving isolated glandular or coronal aberrant location of the urethralmeatus without curvature of the penis;
4. The following ear, nose and throat medical conditions:
a. Tonsillitis,
b. Adenoiditis,
c. Hypertrophic lingual frenum,
d. Nasal polyp,
e. Cranial or temporal mandibular joint syndrome,
f. Simple deviated nasal septum,
g. Recurrent otitis media,
h. Obstructive apnea,
i. Acute perforation of the tympanic membrane,
j. Sinusitis,
k. Isolated preauricular tag or pit, and
l. Uncontrolled salivation;
5. The following musculoskeletal system medical conditions:
a. Ingrown toenail;
b. Back pain with no structural abnormality;
c. Ganglion cyst;
d. Flat foot other than complicated flat foot;
e. Fracture;
f. Popliteal cyst;
g. Femoral anteversion and tibial torsion unless:
i. For an individual less than eight years of age, associated with a neuromuscular disorder that is a CRS condition; or
ii. For an individual eight years of age or older, causing significant functional impairment as determined by a CRS provider;
h. Simple bunion; and
i. Carpal tunnel syndrome;
6. The following gastrointestinal system medical conditions:
a. Malabsorption syndrome, also known as short bowel syndrome,
b. Crohn's disease,
c. Hernia other than a diaphragmatic hernia,
d. Ulcer disease,
e. Ulcerative colitis,
f. Intestinal polyp,
g. Pyloric stenosis, and
h. Celiac disease;
7. The following nervous system medical conditions:
a. Headaches;
b. Central apnea secondary to prematurity;
c. Near sudden infant death syndrome;
d. Febrile seizures;
e. Occipital plagiocephaly, either positional or secondary to lambdoidal synostosis;
f. Trigonocephaly secondary to isolated metopic synostosis;
g. Spina bifida occulta;
h. Near drowning in the acute phase; and
i. Spinal cord injury in the acute phase;
8. The following ophthalmologic medical conditions:
a. Simple refraction error,
b. Astigmatism,
c. Strabismus, and
d. Ptosis;
9. The following respiratory system medical conditions:
a. Respiratory distress syndrome,
b. Asthma,
c. Allergies,
d. Bronchopulmonary dysplasia,
e. Emphysema,
f. Chronic obstructive pulmonary disease, and
g. Acute or chronic respiratory condition requiring venting for the neuromuscularly impaired;
10. The following integumentary system medical conditions:
a. A deformity that is not functionally limiting,
b. Simple nevi,
c. Skin tag,
d. Port wine stain,
e. Sebaceous cyst,
f. Isolated malocclusion that is not functionally limiting,
g. Pilonidal cyst,
h. Ectodermal dysplasia, and
i. A craniofacial anomaly that is not functionally limiting;
11. The following medical conditions:
a. Allergies;

b. Anorexia nervosa or obesity;
c. Autism;
d. A burn other than a burn scar that is functionally limiting;
e. Cancer;
f. Chronic vegetative state;
g. Deformity and dysfunction secondary to trauma or injury if:
   i. The trauma or injury occurred on or after the individual's 16th birthday, or
   ii. Three months have not passed since the trauma or injury;
h. Depression or other mental illness;
i. Developmental delay;
j. Dyslexia or other learning disabilities;
k. Failure to thrive;
l. Hyperactivity;
m. Attention deficit disorder;
n. Leg length discrepancy of less than five centimeters at skeletal maturity; and
o. Immunodeficiency, such as AIDS and HIV.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

ARTICLE 3. REFERRAL; ENROLLMENT; APPLICATION; REDETERMINATION; TERMINATION

Article 3, consisting of Sections R9-7-301 through R9-7-306, made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

R9-7-301. Referral

A. To refer an individual, a referral source shall submit to the Department a referral form containing:
1. The name, sex, home address, and home telephone number of the individual;
2. If the individual is a minor, the name of a parent of the individual;
3. If applicable, the work telephone number of the parent in subsection (A)(2);
4. The name, address, and telephone number of the referral source;
5. If the individual previously received covered medical services or covered support services, the year in which the individual received the covered medical services or covered support services, and the regional contractor responsible for providing covered medical services or covered support services to the individual;
6. Relationship of the referral source to the individual; and
7. If known to the referral source, the individual's:
   a. Birth date,
   b. Diagnosis, and
   c. Physician.

B. If an individual has Title XIX, Title XXI, or other health care insurance, a referral source shall submit to the Department the form in subsection (A) and:
1. Documentation from a physician who evaluated the individual, stating the individual's diagnosis made by the physician; and
2. Diagnostic test results that support the individual's diagnosis made by the physician.

C. If an individual does not have Title XIX, Title XXI, or other health care insurance, a referral source shall submit to the Department the form in subsection (A) and:
1. If the individual has not been evaluated by a physician, the reason the referral source believes that the individual may be eligible for CRS; or
2. If the individual has been evaluated by a physician:
   a. Documentation from the physician who evaluated the individual, stating the individual's diagnosis made by the physician; and
   b. If available, diagnostic test results that support the individual's diagnosis made by the physician.

D. Within 10 business days from the date of receipt of a referral:
1. If the Department determines that a individual may be eligible for CRS, the Department shall notify the referral source and provide the individual or, if the individual is a minor, the individual's parent:
   a. An application form in R9-7-304(1) and a list of the documentation required in R9-7-304(2) through (11);
   b. A written notice that the individual may be eligible for CRS and that:
      i. After the Department receives the application form in R9-7-304(1) from the individual or, if the individual is a minor, the individual's parent, the individual is authorized to receive an initial evaluation to determine whether the individual is medically eligible for CRS;
      ii. The individual or, if the individual is a minor, the individual's parent is required to participate in a eligibility interview before or during the individual's initial evaluation;
      iii. The Department has scheduled an appointment for the individual's initial evaluation at a CRS clinic, the date of the individual's appointment, the address of the CRS clinic, and the procedure for rescheduling the appointment if the individual is unable to keep the scheduled appointment; and
      iv. The individual is not authorized to receive covered medical services or covered support services other than the initial evaluation until the individual and, if the individual is a minor, the individual's parent comply with the application requirements in R9-7-302(B) and the Department determines that the individual meets the eligibility requirements in R9-7-201; and
   c. Information about CRS, including:
      i. An overview of CRS,
      ii. Medical and non-medical eligibility requirements for CRS,
      iii. The application requirements in R9-7-302(B), and
      iv. Criteria for determining which individuals are part of a household income group;
2. If the Department determines that the individual is not eligible for CRS, the Department shall:
   a. Notify the referral source; and
   b. Provide the individual or, if the individual is a minor, the individual's parent a written notice that:
      i. Informs the individual or, if the individual is a minor, the individual's parent that the Department has determined the individual is not eligible for CRS; and
      ii. Complies with A.R.S. § 41-1092.03; or
3. If the Department determines the referral source did not submit the information and documentation required in subsection (A), the Department shall provide a written notice to the referral source that:

a. Identifies the missing documentation or information;
b. Requests the referral source to submit the missing information or documentation within 30 calendar days from the date of the notice; and
c. Informs the referral source that, if the Department does not receive the documentation or information within 30 calendar days from the date of the notice, the Department shall consider the referral withdrawn.

E. If the Department requests information or documents according to subsection (D)(3), and the Department:
1. Receives the requested documentation and information within 30 calendar days from the date of the notice in subsection (D)(3), the Department shall determine whether the individual may be eligible for CRS and notify the referral source and the individual or, if the individual is a minor, the individual's parent according to subsection (D)(1) or (D)(2) within 10 business days from the date of receipt of the requested documentation and information; or
2. Does not receive the requested documentation and information within 30 calendar days from the date of notice in subsection (D)(3), the Department shall consider the referral withdrawn.

F. If the Department determines that an individual may be eligible for CRS, the Department shall schedule the date of an initial evaluation no more than 30 calendar days after the date of the determination.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

R9-7-302. Enrollment

A. An individual or, if the individual is a minor, the individual's parent may apply for enrollment after the individual or, if the individual is a minor, the individual's parent receives the notice in R9-7-301(D)(1) from the Department that the individual may be eligible for CRS.

B. To apply for enrollment:
1. An applicant or, if the applicant is a minor, the applicant's parent shall submit to the Department an application form containing the information in R9-7-304(1);
2. An applicant or, if the applicant is a minor, the applicant's parent shall submit to the Department the documentation in R9-7-304(2) through (11):
   a. Before an applicant's initial evaluation, or
   b. No later than 10 business days after the date an applicant attends a CRS clinic for an initial evaluation;
3. After submitting the application form in subsection (B)(1):
   a. An applicant, or if the applicant is a minor, the applicant's parent shall participate in an eligibility interview; and
   b. An applicant shall attend a CRS clinic for an initial evaluation; and
4. No later than 10 business days after the date an applicant attends a CRS clinic for an initial evaluation, the applicant or, if the applicant is a minor, the applicant's parent shall:
   a. If the applicant is potentially eligible for Title XIX or Title XXI health care insurance, apply for the health care insurance; and
   b. Sign the payment agreement in R9-7-601(B).

C. Except as provided in subsection (H), the Department shall enroll an applicant as soon as:
1. The applicant and, if applicable, the applicant's parent submit the information and documentation and meet the requirements in this Section; and
2. The Department determines the applicant is eligible for CRS.

D. If the Department enrolls an applicant, the Department shall provide the applicant or, if the applicant is a minor, the applicant's parent, a written notice that contains:
1. A statement that the applicant is enrolled in CRS; and
2. Information about CRS that includes:
   a. Covered medical services and covered support services,
   b. Member payment responsibility, and
   c. The grievance and appeal process.

E. The Department shall not enroll an applicant if:
1. The applicant and, if the applicant is a minor, the applicant's parent does not submit the information and documentation or comply with the requirements in this Section; or
2. The Department determines that the applicant is not eligible for CRS.

F. If the Department does not enroll an applicant, the Department shall provide the applicant or, if the applicant is a minor, the applicant's parent, a written notice of denial that complies with A.R.S. § 41-1092.03.

G. The Department shall provide the written notice in subsection (D) or subsection (F) within 10 days from the date of an applicant's initial evaluation or the Department's receipt of the applicant's information and documentation in subsection (B)(2) if the applicant did not submit the information and documentation at the applicant's initial evaluation, whichever is later.

H. If an applicant, who meets the requirements in this Section and is determined to be eligible for CRS, is receiving inpatient services, the Department shall:
1. Provide the applicant or, if the applicant is a minor, the applicant's parent a written notice:
   a. Stating that the Department will not enroll an applicant while the applicant is receiving inpatient services; and
   b. Requesting that the Department is notified when the applicant is no longer receiving inpatient services; and
2. When the applicant is no longer receiving inpatient services, enroll the applicant according to subsection (D).

I. If the Department requests information or documentation to determine if a member remains eligible for CRS, the member or, if the member is a minor, the member's parent shall provide the requested information or documentation to the Department within 30 calendar days of the request.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

R9-7-303. Initial Evaluation; Further Diagnostic Testing

If the Department determines from an applicant's initial evaluation that further diagnostic testing is required to determine whether the applicant is medically eligible for CRS, the Department shall:
1. If the applicant has Title XIX or Title XXI health care insurance, request that AHCCCS complete the diagnostic testing and send the results of the diagnostic testing to the Department;
2. If the applicant has other health care insurance that agrees to pay the Department for the diagnostic testing, complete the diagnostic testing and submit charges for the diagnostic testing to the health insurance company;

3. If the applicant has health care insurance that does not agree to pay the Department for the diagnostic testing but provides the diagnostic testing, request that the applicant have:
   a. The diagnostic testing completed through the applicant's health care insurance company, and
   b. The results of the diagnostic testing sent to the Department; and
4. If the applicant does not have health care insurance or has health care insurance that does not provide or pay for the diagnostic testing, and the applicant:
   a. Signs the payment agreement in R9-7-601(B), provide the diagnostic testing to the individual; or
   b. Does not sign the payment agreement in R9-7-601(B), provide to the applicant or, if the applicant is a minor, the applicant's parent a written notice of denial that complies with A.R.S. § 41-1092.03.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

R9-7-304. Enrollment Application

An applicant applying for enrollment or, if the applicant is a minor, a parent applying on behalf of the applicant shall submit to the Department an application packet including:

1. An application form containing:
   a. The applicant's name, home address, mailing address, birth date, place of birth, and marital status;
   b. If the applicant has a social security number, the applicant's social security number;
   c. If the applicant has a home telephone number, the applicant's home telephone number;
   d. If the applicant does not have a home telephone number, a telephone number where a message may be left for the applicant;
   e. Whether the applicant has a court-appointed legal guardian or custodian;
   f. If the applicant is a minor, the following information for the applicant's parent:
      i. Name;
      ii. Home address, mailing address, and home or message telephone number;
      iii. If the parent has a social security number, the parent's social security number; and
      iv. If the parent works, the parent's employer, work address, and work telephone number;
   g. The names and ages of all individuals in the applicant's household income group;
   h. The annual gross income of the applicant's household income group;
   i. Whether the applicant has Title XIX, Title XXI, or other health care insurance;
   j. If the applicant has health care insurance other than Title XIX or Title XXI health care insurance, for each health care insurance company:
      i. The health care insurance company's name, billing address, and telephone number; and
      ii. For the applicant's health care insurance, the applicant's policy or plan number, health care insurance identification number, effective or end date, and type of services paid for by the health care insurance;
   k. Whether the applicant receives services from the:
      i. DES Adoption Subsidy Program,
      ii. DES Comprehensive Medical and Dental Program, or
      iii. DES Division of Developmental Disabilities;
   l. The signature of the applicant or, if the applicant is a minor, the signature of the applicant's parent in subsection (1)(f); and
   m. The date the application form is signed;
2. If the applicant has a legal guardian, a copy of the court document indicating the applicant's legal guardian;
3. If the applicant has Title XIX or Title XXI health care insurance, the applicant's AHCCCS identification number or a copy of the applicant's AHCCCS identification card;
4. If the applicant has health care insurance other than Title XIX or Title XXI health care insurance, a copy of the applicant's health care insurance card or written documentation that the applicant has health care insurance from the health care insurance company;
5. As proof of the applicant's age, a copy of one of the following documents that includes the applicant's birth date:
   a. An Immigration and Naturalization Service document,
   b. A federal or state census record,
   c. A hospital record of birth,
   d. A certified copy of a birth certificate,
   e. A military record,
   f. A notification of birth registration,
   g. A religious record,
   h. A school record, or
   i. A U.S. passport;
6. Except as provided in subsection (7), as proof of the applicant's U.S. citizenship, one of the following:
   a. A certified copy of a birth certificate,
   b. A certified copy of a religious record issued within three months of birth,
   c. A naturalization certificate reflecting U.S. citizenship,
   d. A current or expired U.S. passport,
   e. A certificate of U.S. citizenship, or
   f. Documentation evidencing that the individual currently has Title XIX or Title XXI health care insurance;
7. If the applicant is a qualified alien, written documentation verifying that the applicant:
   a. Is a qualified alien, and
   b. Meets the requirements of A.R.S. § 36-2903.03(B);
8. As proof that the applicant lives in Arizona, a copy of one of the following documents issued in the name of the applicant, the spouse of the applicant, or an adult with whom the applicant lives:
   a. The applicant's Title XIX or Title XXI health care insurance identification number or a copy of the applicant's current Title XIX or Title XXI health care insurance card;
   b. An Arizona rent or mortgage receipt;
   c. An Arizona lease for where the applicant lives;
   d. A written statement that the applicant lives at an Arizona nursing care institution licensed under A.R.S. Title 36, Chapter 4 signed by the administrator of the Arizona nursing care institution;
   e. An unexpired Arizona motor vehicle operator's license;
   f. A current Arizona motor vehicle registration;
   g. A pay stub from an Arizona employer;
   h. An Arizona utility bill for where the applicant lives;
   i. A current Arizona phone directory listing for where the applicant lives;

j. A United States Post Office record reflecting an Arizona address;
k. A certified copy of a religious record reflecting an Arizona address;
l. A certified copy of a school record reflecting an Arizona address; and
m. An affidavit signed by the applicant or, if the applicant is a minor, by the applicant's parent certifying that:
i. None of the documents in subsections (B)(8)(a) through (B)(8)(l) are available; and
ii. The applicant lives in Arizona;

9. As proof of an applicant's intent to continue to live in Arizona, an affidavit that contains an attestation by the applicant or, if the applicant is a minor, the applicant's parent of the applicant's intent to remain in Arizona;
10. If the applicant does not have Title XIX or Title XXI health care insurance, copies of the following documentation for each individual in the applicant's household income group, if applicable:
a. If an individual in the household income group is employed, the individual's:
i. Pay stubs for the 30 calendar days before the date on the applicant's application form,
ii. Most recent W-2 form, and
iii. Federal tax return most recently filed by the individual;
b. If an individual in the household income group is self-employed, the individual's:
i. Federal tax return, including a schedule C, most recently filed by the individual; or
ii. Most recent quarterly financial statement signed and dated by the individual;
c. Documented evidence of all unearned income received by an individual, such as cancelled checks or court orders for child support payments;
d. Documented evidence of all medical expenses incurred by an individual and paid during the 12 months before the date on the application form; and
e. Documented evidence of all unpaid medical expenses; and
11. If applicable, documented evidence of:
a. Any court award or settlement related to the applicant's CRS condition, and
b. Expenditures from the court award or settlement made for medical services for the applicant.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

R9-7-305. Redetermination

A. At any time, the Department may request a member or, if the member is a minor, the member's parent to submit the information and documents in R9-7-304 to redetermine:
1. Whether a member remains eligible for CRS, or
2. A member's payment responsibility.

B. If the member has Title XIX or Title XXI health care insurance, the Department shall, no later than the member's CRS expiration date:
1. Verify that the member has Title XIX or Title XXI health care insurance, and
2. Establish a new CRS expiration date for the member that is the same as the member's Title XIX or Title XXI health care insurance expiration date.

C. If the member does not have Title XIX or Title XXI health care insurance and the net income of the member's household income group is more than 200% of the Federal Poverty Level, the member or, if the member is a minor, the member's parent shall submit, before the member's CRS expiration date, a signed payment agreement.

D. If the member does not have Title XIX or Title XXI health care insurance and the net income of member's household income group is equal to or less than 200% of the Federal Poverty Level, the member or, if the member is a minor, the member's parent shall, at least 30 calendar days before the CRS expiration date:
1. Participate in an eligibility interview with a Department representative,
2. Submit to the Department the information and documentation in R9-7-304(10), and
3. Submit to the Department a signed payment agreement.

E. The Department shall establish a new CRS expiration date for a member who does not have Title XIX or Title XXI health care insurance that is 12 months after the member's CRS expiration date if:
1. The member and, if the member is a minor, the member's parent comply with the redetermination requirements in this Section before the member's expiration date; and
2. The Department determines that the member remains eligible for CRS.

F. If the Department determines that a member is no longer eligible for CRS, the Department shall provide the member or, if the member is a minor, the member's parent a written notice that:
1. Informs the member that the member is no longer eligible for CRS, and
2. Complies with A.R.S. § 41-1092.03.

G. At any time, a member or, if the member is a minor, the member's parent may request a redetermination of the member's payment responsibility by submitting to the Department:
1. A written request for redetermination, and
2. The documentation and information in R9-7-304(10).

H. Within 30 calendar days from the date of the Department's receipt of a member's request for redetermination, the Department shall provide the member or, if the member is a minor, the member's parent:
1. A written notice of the Department's redetermination;
2. A new CRS expiration date for the member; and
3. If applicable, a revised payment agreement.

I. If the Department changes a member's payment responsibility as a result of a redetermination, and the member does not have Title XIX or Title XXI health care insurance, the member or, if the member is a minor, the member's parent shall sign and submit a revised payment agreement.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

R9-7-306. Termination of Enrollment

A. The Department shall terminate a member's enrollment if:
1. The Department determines the member no longer meets the eligibility requirements in R9-7-201;
2. A member does not continue to have Title XIX or Title XXI health care insurance while the member is eligible for the Title XIX or Title XXI health care insurance; or
3. The member or, if the member is a minor, the member's parent:
a. Requests a termination of the member's enrollment; or
b. Fails to comply with the:
i. Submission requirements in R9-7-302(I) or R9-7-305; or

ii. Signed payment agreement in R9-7-601(B), if applicable.

B. If the Department terminates a member's enrollment, the Department shall:
1. Provide the member or, if the member is a minor, the member's parent a written notice of termination that complies with A.R.S. § 41-1092.03; and
2. If the Department has the name of the member's physician other than a CRS provider, provide the member's physician a written notice of the member's termination.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

ARTICLE 4. COVERED MEDICAL SERVICES

Article 4, consisting of Sections R9-7-401 through R9-7-421, made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

R9-7-401. General Requirements

A. The Department shall not provide covered medical services other than an initial evaluation until the individual and, if the individual is a minor, the individual's parent comply with the application requirements in R9-7-302(B) and the Department determines that the individual meets the eligibility requirements in R9-7-201.

B. The Department shall provide a covered service in this Section:
1. Through a regional contractor,
2. At the regional contractor's facility or a facility under contract with the regional contractor; and
3. Using a CRS provider.

C. The Department shall provide a medical service in R9-7-403 through R9-7-421 to a member if:
1. A regional medical director or the regional medical director's designee determines that the medical service:
   a. Is medically necessary;
   b. Is related to the member's CRS condition; and
   c. Except as provided in subsection (D), is not to treat one of the conditions in R9-7-203; and
2. A CRS provider obtains prior authorization, if applicable according to R9-7-402, for the medical service.

D. If the requirements of subsection (C) are met, the Department shall provide a medical service to a member to treat the following medical conditions:
1. Sinusitis for a member with cystic fibrosis;
2. An ingrown toenail if secondary to a CRS condition;
3. Strabismus for a member with cerebral palsy, myelomeningocele, a shunt, a cataract, glaucoma, a disorder of the optic nerve, retinopathy of prematurity, or a disorder of the iris, ciliary bodies, retina, lens or cornea;
4. Enuresis if secondary to a CRS condition;
5. Otitis media in a member with cleft lip and cleft palate or a sensorineural hearing loss;
6. Nasal polyps for a member with cystic fibrosis;
7. Malabsorption syndrome for a member with cystic fibrosis;
8. Nephritis associated with lupus erythematosis;
9. Hydrocele associated with a ventriculo-peritoneal (VP) shunt;
10. A fracture caused by a CRS condition;
11. Bunions if secondary to a CRS condition;
12. Carpal tunnel syndrome if secondary to a CRS condition;
13. Refraction error for a member with an ophthalmologic CRS condition;
14. Astigmatism for a member with an ophthalmologic CRS condition; or
15. With medication for no more than 30 calendar days, depression secondary to a CRS condition.

E. If a member requires a medical service that meets the requirements of subsection (C) and the medical service is not available in Arizona, the Department shall provide the medical service in another state if:
1. Two physicians, who are CRS providers, practicing a specialty related to the member's CRS condition, each submit in writing to the Department:
   a. A recommendation that the Department provide the medical service in another state; and
   b. A statement that:
      i. The medical service is life-saving for the member, and
      ii. The member is anticipated to experience, as a result of the medical service, functional improvement and that the physician expects the functional improvement to be significant; and
2. A regional medical director and a regional contractor provide written authorization to the Department before the provision of the medical service outside the state of Arizona.

F. If the Department provides a member a medical service in another state, the Department shall not provide transportation or lodging for the member or the member's family.

G. If a member receives a recommendation for treatment from a CRS provider, the member may obtain a recommendation for treatment from a second CRS provider.

H. The Department shall provide the following medical services to a member beyond the limit specifically stated in the applicable subsection if approved by a regional medical director:
1. Home health services in R9-7-406(B),
2. Oxygen and related supplies in R9-7-408(G),
3. Nutrition services in R9-7-410(A),
4. Physical therapy and occupational therapy in R9-7-413,
5. Psychological services in R9-7-416(A),
6. Psychiatric services in R9-7-417(A), and
7. Speech/language pathology services in R9-7-419.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

R9-7-402. Prior Authorization

Except in an emergency, a CRS provider shall obtain prior authorization before providing any of the following to a member:
1. Medical equipment in R9-7-408,
2. Prosthetic and orthotic devices in R9-7-415,
3. Physician services in R9-7-414 provided at a physician's office,
4. Dental services in R9-7-404 provided at a dentist's office,
5. Outpatient diagnostic testing and laboratory services in R9-7-411(2) not provided by a CRS provider,
6. Outpatient surgery in R9-7-411(1),
7. An outpatient positive emission tomography scan,
8. An implantable bone conduction device in R9-7-403(B)(7),
9. A tactile hearing aid in R9-7-403(B)(8), and
10. Admission to a hospital for inpatient services in R9-7-407.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

R9-7-403. Audiology Services

A. If the requirements of R9-7-401(C) are met, the Department shall provide audiology services to a member who has, as determined by a CRS provider, a:
1. Hearing impairment, or
2. CRS condition that poses a risk for hearing impairment.

B. If the requirements in subsection (A) are met, the Department shall provide the following audiology services:
1. A hearing screening;
2. A hearing evaluation;
3. Audiometric testing;
4. The selection, fitting, and dispensing of hearing aids;
5. After the hearing evaluation in subsection (B)(2), a follow-up hearing evaluation;
6. A replacement hearing aid once every three years, or sooner if the replacement hearing aid is for a member who:
   a. Experiences a change in hearing level, as determined by a CRS provider;
   b. Has a hearing aid stolen and submits to the Department a copy of a police report about the theft; or
   c. Loses a hearing aid, and the Department has not replaced the hearing aid within the previous 12 months due to loss;
7. An implantable bone conduction device; and
8. A tactile hearing aid.

C. The Department shall not provide a cochlear implant to a member.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

R9-7-404. Dental and Orthodontia Services

A. If the requirements of R9-7-401(C) are met, the Department shall provide dental services to a member who has one of the following medical conditions:
1. A cleft lip;
2. A cleft palate;
3. A cerebral spinal fluid diversion shunt at risk for subacute bacterial endocarditis;
4. A cardiac condition that causes the member to be at risk for subacute bacterial endocarditis;
5. Dental complications that are a result of treatment for a CRS condition; or
6. A functional malocclusion causing:
   a. Mastication and swallowing abnormalities that affect the nutritional status of the individual, resulting in growth abnormalities;
   b. A respiratory problem that restricts the member's breathing, such as dynamic or static airway obstruction; or
   c. A communication disorder that cannot be further improved by speech therapy alone and that does not have a primary etiology other than the malocclusion, as determined by a CRS provider.

B. If the requirements of R9-7-401(C) are met, the Department shall provide orthodontia services and devices to a member who has one of the following medical conditions:
1. A cleft palate; or
2. A functional malocclusion causing:
   a. Mastication and swallowing abnormalities that affect the nutritional status of the individual, resulting in growth abnormalities;
   b. A respiratory problem that restricts the member's breathing, such as dynamic or static airway obstruction; or
   c. A communication disorder that cannot be further improved by speech therapy alone and that does not have a primary etiology other than the malocclusion, as determined by a CRS provider.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

R9-7-405. Diagnostic Testing and Laboratory Services

A. If the requirements of R9-7-401(C) are met, the Department shall provide the following diagnostic testing to a member:
1. Radiology,
2. Visual evoked response,
3. Computed tomography scan,
4. Ultrasound,
5. Brainstem auditory evoked response,
6. Magnetic resonance imaging,
7. Electroencephalogram,
8. Electrocardiogram, and
9. Echocardiogram.

B. If the requirements of R9-7-401(C) are met, the Department shall provide the following laboratory services to a member:
1. A blood bank, accessible to the member,
2. Pulmonary function testing,
3. Complete blood counts, and
4. Urinalysis.

C. The Department shall provide diagnostic testing and laboratory services, as ordered by a physician, to a member to determine if the member has a CRS condition in addition to the CRS condition diagnosed at the member's initial evaluation.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

R9-7-406. Home Health Services

A. If the requirements in R9-7-401(C) are met, the Department shall provide total parenteral nutrition to a member for no more than 30 calendar days before the member's hospitalization for surgery related to the member's CRS condition.

B. If the requirements in R9-7-401(C) are met, the Department shall provide home health services to a member after the member's hospitalization:
1. If a CRS provider requests that the home health services be provided where the member is located;
2. If the need for home health services is related to the member's CRS condition that was treated during the member's hospitalization; and
3. Except as provided in R9-7-401(G) for no more than 30 calendar days.

C. If the requirements in subsection (B) are met, the Department shall provide the following home health services:
1. An evaluation of the member's need for home health services,
2. Intravenous therapy,
3. Wound care,
4. Administration of medications,
5. Monitoring the member's vital signs to determine whether the member's vital signs are within the range established as acceptable for the member by a CRS provider,
6. Monitoring oxygen administration to determine whether the member's breathing is within the range established as acceptable for the member by a CRS provider,
7. Physical therapy,
8. Occupational therapy,
9. Enterostomy care,

10. Urethral catheter insertion and care, and
11. Instruction for the provision of home health services to the member or the member's caregivers.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

R9-7-407. Inpatient Services

A. If the requirements in R9-7-401(C) are met, the Department shall provide inpatient services to a member who requires hospitalization related to the member's CRS condition.
1. If a member's hospitalization is no longer related to the member's CRS condition, the Department shall not provide inpatient services to the member.
2. If a member requires inpatient services to determine whether the member has ventricular infection or ventricular shunt failure, the Department shall provide inpatient services until the date the regional medical director or the regional medical director's designee determines that the member does not have ventricular infection or ventricular shunt failure.

B. If the requirements in R9-7-401(C) are met, the Department shall provide transportation for a member from one hospital that is a CRS provider to another hospital that is a CRS provider if:
1. Ordered by a CRS provider, and
2. Authorized in writing by a regional medical director.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

R9-7-408. Medical Equipment

A. If the requirements of R9-7-401(C) are met and subject to the limitations in subsections (B) through (D), the Department shall provide a non-motorized wheelchair or an ambulation assistive device to a member.

B. The Department shall provide a tilt-in-space wheelchair to a member only if a change in the member's position is necessary to provide medically necessary services such as tracheotomy care or feeding.

C. The Department shall not provide a member with:
1. A wheelchair or an ambulation assistive device if the wheelchair or ambulation assistive device is for use at school only,
2. A second non-motorized wheelchair if the member already has a non-motorized wheelchair that is operational, or
3. A second ambulation assistive device if the member already has an ambulation assistive device that is operational.

D. The Department shall provide a tray for a member's wheelchair if a CRS provider states in writing that the member's use of the tray is likely to result in the member's functional improvement.

E. The Department shall provide a cranial modeling band for a member who:
1. Is 24 months of age or younger;
2. Has undergone CRS-approved cranial modeling surgery; and
3. Demonstrates postoperative progressive loss of surgically achieved correction that, without intervention, may require additional remodeling surgery.

F. The Department shall provide a stroller for a member if a CRS provider determines that the stroller is medically necessary to provide modified seating for positioning the member.

G. Except as provided in R9-7-401(G), the Department shall provide oxygen and related supplies for no more than 30 calendar days to a member if ordered by a CRS provider.

H. The Department shall replace or make a change to the medical equipment provided to a member if the replacement or change is:
1. Recommended by a CRS provider; and
2. Necessary due to a change in the member's physical size, functional level, physical safety, or medical condition.

I. In addition to subsection (H), the Department shall replace medical equipment provided to a member if the medical equipment:
1. Is not safe to operate and cannot be repaired to be safe to operate as determined by a CRS provider;
2. Is stolen and the member or, if the member is a minor, the member's parent submits to the Department:
   a. A written request for replacement medical equipment, and
   b. A copy of a written police report about the stolen medical equipment; or
3. Is lost and has not been replaced by the Department within the previous 12 months due to loss.

J. The Department shall make a repair to a member's medical equipment if:
1. A written determination by a CRS provider that the repair to the medical equipment is medically necessary for the member is submitted to the Department;
2. The need for repair is not due to the member's misuse of the medical equipment; and
3. The repair is to:
   a. Medical equipment provided by the Department; or
   b. A wheelchair that, although not provided to the member by the Department, has been determined by a CRS provider to be safe and appropriate for the member.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

R9-7-409. Nursing Services

If the requirements of R9-7-401(C) are met, the Department shall provide nursing services to a member.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

R9-7-410. Nutrition Services

A. If the requirements of R9-7-401(C) are met, the Department shall provide the following nutrition services to a member:
1. An evaluation of the member's nutritional needs;
2. Total parenteral nutrition according to R9-7-405(A);
3. If ordered by a CRS provider:
   a. Nutrition, other than listed in subsection (B), for the treatment of a metabolic disorder; and
   b. For providing nutrition through a tube;
      i. Equipment; and
      ii. Except as provided in R9-7-401(G), a commercial product for no more than 30 calendar days; and
4. If ordered by a CRS provider for a member with cystic fibrosis, and not available through a source other than CRS, a commercial product:
   a. For a member who is not receiving nutrition through a tube, that supplies 50% of the member's daily caloric need;

b. For a member who is receiving nutrition through a tube, that supplies 100% of the member's daily caloric need; and
c. Except as provided in R9-7-401(G), for no more than 30 calendar days.

B. The Department shall not provide:
1. Lactose-free nutrition for galactosemia,
2. A nutrition formula or a milk product used for the purpose of combining with a modified amino acid formula, or
3. Low protein nutrition.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

R9-7-411. Outpatient Services
If the requirements of R9-7-401(C) are met, the Department shall provide the following outpatient services to a member:
1. Outpatient surgery;
2. Diagnostic testing and laboratory services in R9-7-405;
3. Emergency services in a hospital;
4. CRS clinics;
5. Evaluation and treatment at:
   a. An outreach clinic, or
   b. A regional clinic.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

R9-7-412. Pharmaceutical Services
A. If the requirements of R9-7-401(C) are met, the Department shall provide pharmaceutical services to a member.
B. The Department shall provide growth hormone therapy ordered by a physician for a member who has been diagnosed by a CRS provider with panhypopituitarism.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

R9-7-413. Physical Therapy and Occupational Therapy
A. If the requirements of R9-7-401(C) are met, the Department shall provide physical therapy or occupational therapy to a member only:
1. Before a scheduled surgery;
2. After a surgery;
3. After removal of a cast;
4. If a medication used to treat the member's CRS condition causes impairment to a neurologic or orthopedic function;
5. After the member receives an orthotic or prosthetic device;
6. After a hospitalization; and
7. If the member:
   a. Is unable to obtain physical therapy or occupational therapy through a source other than CRS, and
   b. Has a strong potential for rehabilitation as determined by a CRS provider.

B. Except as provided in R9-7-401(G), the Department shall provide no more than 24 sessions of physical therapy or 24 sessions of occupational therapy for each occurrence in subsection (A).

Historical Note
New Section made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

R9-7-414. Physician Services
If the requirements of R9-7-401(C) are met, the Department shall provide physician services to a member.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

R9-7-415. Prosthetic and Orthotic Devices
A. If the requirements of R9-7-401(C) are met, and subject to the limitations in subsection (B), the Department shall provide a prosthetic device or an orthotic device to a member to enhance the member's ability to perform an activity of daily living.
B. The Department shall not provide:
1. A myoelectric prosthetic device, or
2. Prosthetic shoes.

C. The Department shall replace or make a change to a prosthetic device or orthotic device provided to a member if the replacement or change is:
1. Recommended by a CRS provider;
2. Necessary due to a change in the member's physical size, functional level, physical safety, or medical condition.

D. The Department shall make a repair to a prosthetic device or orthotic device provided by the Department if:
1. The repair is determined to be medically necessary by a CRS provider, and
2. The need for repair is not due to the member's misuse of the prosthetic device or orthotic device.

E. In addition to subsection (C), the Department shall replace a prosthetic device or orthotic device provided to the member if the prosthetic device or orthotic device:
1. Is stolen and the member or, if the member is a minor, the member's parent submits to the Department:
   a. A written request for a replacement prosthetic device or orthotic device, and
   b. A copy of a police report about the stolen prosthetic or orthotic device; or
2. Is lost and the prosthetic device or orthotic device has not been replaced by the Department within the previous 12 months due to loss.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

R9-7-416. Psychological Services
A. If the requirements of R9-7-401(C) are met, the Department shall provide the following psychological services to a member:
1. Crisis intervention services,
2. An evaluation by a psychologist, and
3. Based on a psychologist's evaluation, a recommendation by the psychologist to a psychiatrist for psychiatric services or a psychologist for psychological services.

B. Except as provided in R9-7-401(G), the number of sessions in subsection (A) provided to a member shall not exceed three per calendar year.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

R9-7-417. Psychiatric Services
A. If the requirements in R9-7-401(C) are met, the Department shall provide psychiatric services to a member who has received an evaluation and recommendation for psychiatric services from a psychologist who is a CRS provider.

B. Except as provided in R9-7-401(G), the number of sessions provided to a member according to subsection (A) shall not exceed one per calendar year.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

R9-7-418. Social Work Services
The Department shall provide the following social work services to a member or the member's family:
1. An initial psychosocial evaluation performed by a social worker within the member's first three visits to a CRS clinic, regional clinic, or outreach clinic;
2. Subsequent psychosocial evaluations of a member and the member's family performed by a social worker based on the initial psychological evaluation; and
3. Recommendations, based on a psychosocial evaluation, to community resources.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

R9-7-419. Speech/Language Pathology Services
A. If the requirements of R9-7-401(C) are met, the Department shall provide speech/language pathology services to a member:
1. Before a scheduled surgery;
2. After a surgery;
3. If a medication used to treat the member's CRS condition causes neurological impairment;
4. After a hospitalization; and
5. If the member is not able to obtain speech/language pathology services through a source other than CRS.

B. Except as provided in R9-7-401(G), the Department shall provide no more than 24 sessions of speech/language pathology services for each occurrence in subsection (A).

Historical Note
New Section made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

R9-7-420. Transplants
If the requirements of R9-7-401(C) are met, the Department shall provide a corneal transplant or a bone-grafting transplant to a member.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

R9-7-421. Vision Services
If the requirements of R9-7-401(C) are met, the Department shall provide the following vision services to a member:
1. Eye examinations;
2. Eyeglasses;
3. Contact lenses;
4. Lens enhancements such as UV tinting and safety glass; and
5. For broken or lost eyeglasses or contact lenses, one replacement per prescription per calendar year.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

ARTICLE 5. COVERED SUPPORT SERVICES

Article 5, consisting of Sections R9-7-501 through R9-7-506, made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

R9-7-501. General Requirements
The Department shall provide a support service in this Section:
1. Through a regional contractor,
2. At the regional contractor's facility or a facility under contract with the regional contractor; and
3. Using a CRS provider.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

R9-7-502. Advocacy Services
The Department shall provide the following advocacy services:
1. Explaining the CRS application requirements in R9-7-302(B) to an applicant or, if the applicant is a minor, the applicant's parent and assisting the applicant or applicant's parent in completing the application;
2. Providing CRS orientation to a member and a member's family;
3. Assisting a member and the member's family in obtaining and understanding information for making decisions about the member's medical care;
4. Assisting the member and the member's family in understanding and accessing available community resources for children and families of children with special health care needs;
5. Explaining to a member and the member's family the member's rights and responsibilities related to CRS; and
6. Collaborating with non-CRS providers, schools, and state or federal agencies on behalf of a member.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

R9-7-503. Child Life Services
The Department shall provide the following child life services to a member:
1. Activities in which a member is encouraged to express the member's feelings regarding the member's CRS condition and treatment related to the member's CRS condition;
2. Information provided to the member or the member's family about coping with the member's CRS condition and treatment related to the member's CRS condition;
3. Before the member's surgery and while recovering from surgery, activities designed to decrease the member's fear of surgery;
4. Information provided to the member at the member's comprehension level before a treatment to decrease the member's fears by increasing the member's understanding of the:
   a. Nature of the treatment;
   b. Purpose for the treatment; and
   c. If applicable, the sequence in which treatments may be used; and
5. Emotional support for the member and the member's family before and during surgery or treatment.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

R9-7-504. Education Coordination
The Department shall provide the following education coordination:
1. Informing the member's family about schools and instruction that may meet the member's special education needs;

2. Making recommendations to parents and schools regarding the member's special education needs;
3. Consulting with the member, the member's family, and school personnel regarding the member's transition under R9-7-505;
4. Coordinating the member's instruction with the member's teachers while the member is receiving inpatient services and after the member's hospitalization; and
5. Providing information about CRS to school and education personnel.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

R9-7-505. Transition Services

A. The Department shall assist a member in the member's transition from receiving covered medical services and covered support services from CRS to receiving services from another source.

B. When a member is 14 years of age, the Department shall develop and implement an on-going plan to transition the member from pediatric care to adult care that:
1. Is developed with the member, the member's family, and the member's physician; and
2. Includes a process for the transition of the member's care to a physician who provides physician services to adults.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

R9-7-506. Transportation Services The Department shall provide transportation to a member:
1. From a regional clinic or an outreach clinic to a hospital that is a CRS provider, if medically necessary to respond to an immediate threat to the life or health of the member; or
2. For a transfer between two hospitals that are CRS providers according to R9-7-406(B).

Historical Note

New Section made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

ARTICLE 6. MEMBER PAYMENT

Article 6, consisting of Sections R9-7-601 through R9-7-604, made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

R9-7-601. General Requirements

A. The Department shall determine an applicant's or member's payment responsibility for covered medical services by:
1. Identifying the applicant's or member's household income group;
2. Calculating the net income of the applicant's or member's household income group by subtracting allowable deductions in R9-7-603 from the gross income of the applicant's or member's household income group; and
3. Determining whether the net income of the member's household income group is:
   a. At or below 200% of the Federal Poverty Level, or
   b. More than 200% of the Federal Poverty Level.

B. Before the Department enrolls an applicant, the applicant or, if the applicant is a minor, the applicant's parent, shall sign a payment agreement containing:
1. The applicant's name;
2. The applicant's date of birth;
3. The applicant's payment responsibility established according to R9-7-604;
4. A promise to pay the cost of covered medical services up to the total amount of any:
   a. Court award or settlement of a claim related to the applicant's CRS condition, less money from the court award or settlement expended by the applicant for medical services;
   b. Health care insurance payment or reimbursement to which the applicant is entitled for the covered medical services; and
   c. Other third-party payment or reimbursement to which the applicant is entitled for the covered medical services;
5. A promise to pay according to the applicant's payment responsibility for covered medical services when subsection (B)(4) does not apply;
6. An assignment of insurance benefits;
7. The expiration date of the payment agreement;
8. The gross income of the applicant's household income group;
9. Total deductions;
10. The number of individuals in the applicant's household income group;
11. The signature of the applicant or, if the applicant is a minor, the applicant's parent and date signed; and
12. The signature of the Department's representative and date signed.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

R9-7-602. Identification of Household Income Group

A. At the time of application or redetermination, the Department shall identify a member's household income group as:
1. If the member is living with a parent of the member, that parent's household income group;
2. If the member is living with an individual other than a parent of the member and a parent of the member claims the member as a dependent for tax purposes for the current tax year, that parent's household income group; or
3. If the member is living with an individual other than a parent of the member and neither parent claims the member as a dependent for tax purposes, the household income group of the individual with whom the member lives.

B. The Department shall consider any of the following, when living together, a household income group:
1. A married couple and children of either or both,
2. An unmarried couple and children of either or both;
3. A married couple when both are over the age of 21 years;
4. A married couple when either one or both are under the age of 21 years with no children;
5. A single parent and the single parent's children;
6. An applicant or a member between the ages of 18 years and 21 years; or
7. If living with an applicant or a member, one of the groups in subsections (B)(1) through (B)(5), the applicant or member, and:
   a. The applicant's or member's spouse,
   b. A child of the applicant's or member's spouse,
   c. A child of the applicant or member, and
   d. The other parent of the applicant's or member's child.

C. In addition to the individuals in subsection (B), the Department shall include in a household income group an individual who is not living with the household if:
1. The individual is absent from the household for 30 calendar days or less,
2. The individual contributes to the income of the household, or
3. The parent of the individual claims the individual as a dependent on the parent's income tax.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

R9-7-603. Calculating Net Income

A. Except as provided in subsection (B), a household income group's gross income includes all the earned income and unearned income of the individuals in the household income group.
1. For an individual in the household income group who is not self-employed, the Department shall calculate an individual's annual income using the pay stubs required in R9-7-304(10)(a)(i); and
2. For an individual in the household income group who is self-employed, the Department shall calculate an individual's annual income using the individual's federal tax return or most recent quarterly financial statement required in R9-7-304(10)(b).

B. Gross income does not include:
1. The items in A.C.C. R9-22-1419(C), and
2. The first $50.00 per month per child of child support payments paid by an individual in the household income group.

C. When calculating net income, the Department shall deduct the following from the gross income of the household income group in R9-7-602:
1. For each month the household income group received earned income, a deduction for dependent care that is equal to the AHCCCS allowable deduction in A.A.C. R9-22-1429(E)(2), if the individual who received the earned income and the individual who received dependent care are living in the household;
2. For each individual in the household income group who earned income, an allowance of $90.00 for each month the individual earned income; and
3. The following medical expenses:
   a. Unpaid medical expenses that are:
      i. Incurred by any individual in the household income group before an application form is submitted or a redetermination is requested; and
      ii. Not subject to any applicable third party payment or reimbursement; and
   b. Medical expenses for any individual in the household income group that are:
      i. Paid by an individual in the household income group during the 12 months before an application form is submitted or a redetermination is requested, and
      ii. Not subject to any third party payment or reimbursement.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).

R9-7-604. Member Payment Responsibility

A. A member shall pay the cost for covered medical services provided by the Department up to the total amount of any:
1. Court award or settlement of a claim for the member's CRS condition less money from the court award or settlement expended for medical services for the member;
2. Health care insurance payment or reimbursement to which the member is entitled for covered medical services; and
3. Other third-party payment or reimbursement to which the member is entitled for covered medical services;

B. Except as provided in subsection (A), the Department shall not require a member whose household income group's net income is equal to or less than 200% of the Federal Poverty Level to pay for a covered medical service, except the Department may charge the member a $5.00 co-payment for the non-emergency use of a hospital's emergency services to treat a CRS condition.

C. A member whose household income group's net income is greater than 200% of the Federal Poverty Level shall pay for a covered medical service an amount not to exceed the AHCCCS capped fee-for-service rate for the covered medical service.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 691, effective February 3, 2004 (Supp. 04-1).